

Assessing Nurses' Attitudes Toward Death and Caring for Dying Patients in a Comprehensive Cancer Center

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Purpose/Objectives: To assess how nurses employed in a comprehensive cancer center feel about death and caring for dying patients and examine any relationships between their attitudes and demographic factors.

Design: Descriptive quantitative.

Setting: A 432-bed comprehensive cancer center in New York, NY.

Sample: A convenience sample of 355 inpatient and outpatient oncology nurses.

Methods: Voluntary and anonymous completion of the Frommelt Attitude Toward Care of the Dying (FATCOD), the Death Attitude Profile-Revised (DAP-R), and a demographic questionnaire.

Main Research Variables: Years of total nursing experience, years employed at the cancer center, previous experience with caring for dying patients, age, gender, and attitudes toward death and caring for dying patients.

Findings: Statistically significant relationships were noted among age, nursing experience, previous experience with caring for terminally ill patients, and scores on the FATCOD and DAP-R. Nursing experience and age were the variables most likely to predict nurses' attitudes toward death and caring for dying patients.

Conclusions: RNs with more work experience tended to have more positive attitudes toward death and caring for dying patients.

Implications for Nursing: Based on the data collected in the study, less experienced oncology nurses will most likely benefit from increased education, training, and exposure to providing and coping effectively with end-of-life care.

Oncology nurses often care for patients in all stages of disease, from diagnosis to death or survivorship. A nurse's caseload in a shift can consist of patients in varying phases of illness, presenting a challenge to nurses who must constantly adjust to the different needs of each patient and their families. The attitudes of nurses toward death and dying patients may influence the care RNs are able to provide (Rooda, Clements, & Jordan, 1999). As the literature suggests, implementing an educational program tailored to oncology nurses' needs may be useful in helping to foster more positive attitudes toward death and dying patients, therefore providing quality end-of-life (EOL) care. A baseline assessment of nurses' attitudes toward death and caring for dying patients was conducted prior to designing, testing, and implementing such a program.

Key Points . . .

- Oncology nurses may not always be comfortable caring for dying patients.
- Oncology nurses were found to have a generally positive attitude toward caring for dying patients, although nurses with more years of work experience had the most positive attitudes.
- Implementing educational programs at the time of staff orientation may offer less experienced nurses the knowledge they need to begin to provide care to dying patients and enable them to provide optimal care at the end of life.

Literature Review

Several studies explore the attitudes of nurses caring for dying patients; however, the studies primarily have examined the points of view of homecare, hospice, and medical-surgical nurses. A gap in the literature exists as to how nurses caring for patients with cancer in a comprehensive cancer center view death and care of the dying. The literature also was reviewed for the effectiveness of nursing education interventions on nurses' attitudes toward caring for dying patients.

Rooda et al. (1999) used a convenience sample of 403 nurses from a private hospital and the Visiting Nurse Association Hospice Division and found that nurses with a greater fear of death exhibited fewer positive attitudes toward caring

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for dying patients. Nurses who viewed death as a passageway to a happy afterlife demonstrated a more positive attitude in their care. Contact with terminally ill patients was shown to be a strong predictor of nurses' attitudes. Dunn, Otten, and Stephens (2005) replicated this study in an oncology setting, using a sample of 58 oncology and medical-surgical nurses. Their results indicated that nurses with greater exposure to dying patients reported more positive attitudes. They did not find any significant correlation between nurses' attitudes toward death and caring for dying patients.

In 2003, Frommelt observed undergraduate students ($N = 115$) who participated in a semester-long educational program related to death to determine if attitudes toward death changed after the course. The study found the intervention group developed more positive attitudes toward death, whereas the control group experienced no significant change. The findings were similar to another smaller study (Frommelt, 1991) that examined 34 midwestern nurses' attitudes toward death before and after an educational intervention, with a positive change in attitude after the intervention. Wesel and Rutledge (2005) also used before and after testing to explore whether a video-, reading-, and writing-based intervention positively affected attitudes of homecare and hospice nurses toward death ($N = 33$); their results suggested it did.

A study of 410 pediatric nurses in a major children's hospital indicated that individual nurses' level of hope was associated with comfort and competence in providing palliative care. The nurses reported feeling most competent regarding pain and symptom management but least competent when talking to children and parents about death and dying. Nurses with more years in practice, more hours of palliative care education, and higher hope scores were more comfortable caring for dying children and their families, found it easier to talk to about death and dying, and reported higher levels of palliative care competency (Feudtner et al., 2007).

Additional studies in the field of palliative care have indicated that, to provide quality EOL care and establish meaningful and supportive relationships with patients and their families, healthcare providers themselves must be comfortable with death and dying (Frommelt, 2003; Kane, Hellsten, & Coldsmith, 2004). Communication with patients and their families regarding all aspects of their care, in particular EOL care, is critical. However, training in communication generally is lacking (Merckaert, Libert, & Razavi, 2005). Frommelt (1991) also found that nurses were unhappy with the education they received on the topic of death and dying. Therefore, the purpose of the present study was to assess how nurses employed in a comprehensive cancer center felt about death and caring for dying patients and to examine any relationships between their attitudes and demographic factors.

Conceptual Framework

The Nursing Role Effectiveness Model is based on the Structure-Process Outcome Model of Quality Care (Doran, Sidani, Keatings, & Doidge, 2002). The model analyzes specific nurse and patient variables that may affect nurses' role performance and subsequently, influence patient outcomes. Nurse structural variables, such as education and work experience, are shown to have positive effects on

communication, contributing to improved patient outcomes. The process component of the model encompasses the roles nurses assume when delivering patient care, including independent, interdependent, and dependent activities. Independent activities consist of actions such as patient assessment, intervention, planning, and initiating and ensuring patient comfort. The outcome component examines nursing-sensitive patient outcomes and patients' perceived nursing care benefit. According to Sidani and Irvine (1999), "The Nursing Role Effectiveness Model provides a way to conceptualize nurses' contributions to health care and has proven useful for understanding the influence of unit and nurse structural variables on nursing practice and patient outcome achievement" (p. 60).

Methods

The present study used a descriptive, quantitative design using two self-administered questionnaires. RNs employed throughout the hospital were invited to participate in the study during annual RN competency review days or during nursing orientation. Because data obtained in the study were recorded in a manner in which the subject was not identified, the research was exempt from institutional review board review (U.S. Department of Health and Human Services, 2004). Survey packets consisted of two valid and reliable instruments and a brief demographic questionnaire. Data were collected from January 2006 to December 2006. The principal investigator (PI) or co-PI gave a brief introduction regarding the project to each group and left the instrument packets in a general location for interested participants to pick up. Completed surveys were placed in a labeled box. No identifying information was collected from the participants, ensuring the results were anonymous. Completion of the instruments took approximately 10–15 minutes, and no compensation was provided to the participants.

Instruments

Demographic data, including gender, age, previous experience working with terminally ill patients, work setting (inpatient versus outpatient), years practicing as an RN, and years employed at the cancer center were collected.

The **Frommelt Attitude Toward Care of the Dying (FATCOD) Scale**, Form B (Frommelt, 1991) is a 30-item tool using a five-point Likert scale to indicate respondents' attitudes toward caring for dying patients. The instrument consists of an equal number of positively and negatively worded statements with response options of strongly disagree, disagree, uncertain, agree, and strongly agree. Positive items are scored one (strongly disagree) to five (strongly agree). Scores are reversed for negative items. Possible scores can range from 30–150. A higher score indicates a more positive attitude toward caring for this patient population (see Figure 1).

Reliability of the FATCOD has been established multiple times. Frommelt used a test-retest method with a sample of 18 oncology nurses wherein nurses responded to the instrument and repeated it again three weeks later. The computed Pearson coefficient was found to be 0.94. A sample of 30 nurses (mixed oncology and surgical) later was used to strengthen reliability of the FATCOD. The Pearson coefficient was determined to be 0.90. The content validity index

1. Giving care to the dying person is a worthwhile experience.
2. Death is not the worst thing that can happen to a person.
3. I would be uncomfortable talking about impending death with the dying person.
4. Caring for the patient's family should continue throughout the period of grief and bereavement.
5. I would not want to care for a dying person.
6. The nonfamily caregivers should not be the ones to talk about death with the dying person.
7. The length of time required to give care to a dying person would frustrate me.
8. I would be upset when the dying person I was caring for gave up hope of getting better.
9. It is difficult to form a close relationship with the dying person.
10. There are times when death is welcomed by the dying person.
11. When a patient asks, "Am I dying?" I think it is best to change the subject to something cheerful.
12. The family should be involved in the physical care of the dying person.
13. I would hope the person I'm caring for dies when I am not present.
14. I am afraid to become friends with a dying person.
15. I would feel like running away when the person actually died.
16. Families need emotional support to accept the behavior changes of the dying person.
17. As a patient nears death, the nonfamily caregiver should withdraw from his or her involvement with the patient.
18. Families should be concerned about helping their dying member make the best of his or her remaining life.
19. The dying person should *not* be allowed to make decisions about his or her physical care.
20. Families should maintain as normal an environment as possible for their dying member.
21. It is beneficial for the dying person to verbalize his or her feelings.
22. Care should extend to the family of the dying person.
23. Caregivers should permit dying persons to have flexible visiting schedules.
24. The dying person and his or her family should be the in-charge decision makers.
25. Addiction to pain-relieving medication should not be a concern when dealing with a dying person.
26. I would be uncomfortable if I entered the room of a terminally ill person and found him or her crying.
27. Dying persons should be given honest answers about their condition.
28. Educating families about death and dying is not a nonfamily caregiver's responsibility.
29. Family members who stay close to a dying person often interfere with the professional's job with the patient.
30. It is possible for nonfamily caregivers to help patients prepare for death.

Figure 1. Frommelt Attitude Toward Care of the Dying Instrument

Note. Copyright 1988 by Katherine H. Murray Frommelt. Used with permission.

(CVI) of the FATCOD in 1988 was 1.00 with a computed inter-rater agreement of 0.98. The CVI was repeated in 1998 with an inter-rater agreement of 1.00.

The **Death Attitude Profile-Revised (DAP-R)** (Wong, Reker, & Gesser, 1994) is a 32-item scale that uses a seven-point Likert scale to measure respondents' attitudes toward death. The scale is comprised of five subscales to determine respondents' feelings of (a) fear of death—negative thoughts and feelings about death, (b) death avoidance—avoidance of thoughts of death as much as possible, (c) neutral acceptance—death is neither welcomed nor feared, (d) approach ac-

ceptance—death is viewed as a passageway to happy afterlife, and (e) escape acceptance—death is viewed as an escape from a painful existence. The mean subscale score is computed by adding the scores on each of the individual subscales, from one (strongly agree) to seven (strongly disagree) and then dividing by the number of items included in that subscale. A higher score indicates a stronger tendency to identify with that particular subscale. Wong et al. (1994) demonstrated the reliability of the DAP-R using alpha coefficients of internal consistency and four-week test-retest coefficients.

Data Analysis

Descriptive statistics were used to analyze the demographic data. The Kruskal-Wallis and Mann-Whitney U tests were applied to the survey data, with post-hoc testing using the Tamhane and Dunnett T3 tests. SPSS® version 13.0 was used for analysis.

Results

Sample

The convenience sample consisted of 355 RNs. Ninety-three percent of respondents were female, with 36% between the ages of 30–39 years. Almost 75% of the sample had been RNs for five or more years, with more than 60% working at the cancer center for five or more years and having experience working with dying patients (see Table 1).

Average scores on the DAP-R subscales ranged from 2.54 (avoidance subscale) to 5.59 (neutral subscale). The average score for all respondents on the FATCOD was 4.30, indicating a strongly positive attitude toward caring for dying patients (see Table 2).

Table 1. Demographic Characteristics

Variable	n	%
Age (years)		
20–29	89	25
30–39	128	36
40–49	92	26
50+	46	13
Years as RN		
0–1	43	12
2–4	48	14
5–10	92	26
11+	172	48
Years at cancer center		
0–1	60	17
2–4	74	21
5–10	107	30
11+	114	32
Work setting		
Inpatient	195	55
Outpatient	141	40
Both or other	19	5
Experience with death or dying patients		
Yes	213	60
No	142	40
Gender		
Female	331	93
Male	24	7

N = 355

Table 2. Mean Scores by Scale or Subscale

Scale or Subscale	\bar{X}	SD
DAP-Fear	3.68	1.24
DAP-Avoidance	2.54	1.11
DAP-Neutral	5.59	0.71
DAP-Approach	4.85	1.19
DAP-Escape	3.93	1.26
FATCOD	4.30	0.36

N = 355

DAP—Death Attitude Profile; FATCOD—Frommelt Attitude Toward Care of the Dying

Age

Comparisons using the Kruskal-Wallis test showed significant differences among the age groups on the DAP-avoidance ($p = 0.033$), DAP-neutral ($p = 0.004$), and DAP-escape ($p = 0.002$) subscales and the FATCOD ($p = 0.003$). Post-hoc testing revealed that RNs aged 50 years or older scored higher on DAP-avoidance than RNs aged 20–29 years ($p = 0.007$), indicating that the older RNs were more likely to avoid thinking about death than the younger subset of RNs. In addition, nurses aged more than 50 years scored higher on DAP-neutral than those aged 20–29 years ($p = 0.035$) and 30–39 years ($p = 0.004$), suggesting that older RNs had a tendency to view death with a neutral mindset, neither welcoming nor fearing death. They also scored higher on DAP-escape than RNs aged 20–29 years ($p = 0.001$), 30–39 years ($p = 0.009$), and 40–49 years ($p = 0.037$), suggesting they viewed death as an escape from a painful existence.

On the FATCOD, RNs aged 50 years and older scored higher than RNs aged 20–29 years ($p = 0.012$), and RNs aged 40–49 years scored significantly higher than RNs aged 20–29 ($p = 0.007$), suggesting the older RNs exhibited more positive attitudes toward caring for dying patients.

Nursing Experience

Nursing experience, number of years as an RN, number of years at the cancer center, and previous work with dying patients also were explored. Respondents with varying years of employment as a nurse scored significantly differently on the DAP-avoidance ($p = 0.015$) and DAP-escape ($p = 0.001$) subscales and the FATCOD ($p < 0.0001$). Although scores did not significantly differ among the four individual “years as an RN” categories on the DAP-avoidance, RNs working 11 years or more scored higher on the DAP-escape subscale than RNs working 5–10 years ($p = 0.001$), suggesting that RNs with more years of work experience viewed death as an escape from a painful existence. In addition, RNs working 11 years or more scored significantly higher on the FATCOD than RNs working 0–1 years ($p = 0.012$) and 2–4 years ($p = 0.005$), supporting the finding that older RNs have a more positive attitude toward caring for dying patients than their younger counterparts (see Table 3).

Respondents’ experience working at the cancer center revealed significant differences on DAP-neutral ($p = 0.020$) and DAP-escape ($p = 0.002$) subscales and the FATCOD ($p = 0.012$). RNs employed at the cancer center 0–1 years scored higher on DAP-escape than RNs employed 2–4 years ($p = 0.008$) and 5–10 years ($p = 0.01$), which suggests that

newer employees at the cancer center tend to view death as an escape more so than their slightly more experienced counterparts. RNs employed 11 years or more scored higher on FATCOD than RNs employed 2–4 years ($p = 0.028$), reinforcing previous findings that additional working experience leads to more positive feelings toward death.

The Mann-Whitney U Test revealed that RNs with previous experience working with dying patients scored significantly higher on the FATCOD ($p < 0.0001$), whereas nurses without experience scored higher on the DAP-fear ($p = 0.05$) and DAP-avoidance ($p < 0.0001$) subscales. This indicated that greater exposure and experience in working with dying patients correlated to more positive attitudes in caring for dying patients. RNs without this experience had more negative attitudes, reported more feelings of fear toward death, and avoided thoughts of death as much as possible.

Discussion

The findings of the present study of oncology nurses’ attitudes toward death and caring for dying patients correlate with the attitudes of nurses in other specialties and strongly support the findings of Dunn et al. (2005) in a much larger sample. Viewing death from a neutral or escape perspective correlates with a more positive attitude toward caring for dying patients and their families; this leads to improved patient outcomes and satisfaction for the patient, family, and nurse providing the EOL care.

The Nursing Role Effectiveness Model (Irvine, Sidani, & Hall, 1998) shows that nurse structural variables, such as education and work experience, are shown to have positive effects on communication, contributing to improved patient outcomes. Feudtner et al. (2007) reported that nurses with more years of nursing practice, more hours of palliative care education, and higher levels of hope were more comfortable providing care to dying children and their families, had less difficulty talking about death and dying, and showed increased levels of palliative care competency.

In the present study, years working as an RN, age, and years employed at a cancer center emerged as the strongest indicators of exhibiting a positive attitude toward caring for dying patients. Years of experience also correlated with viewing death as an escape from a painful existence.

Limitations

Several limitations should be considered when interpreting the results of the study. The respondents were predominantly female, with almost 75% having worked as RNs for five or more years. Although larger than similar studies, the sample size of 355 oncology nurses working in a major cancer center may limit the generalizability of the study findings to nurses providing care to other patient populations. Self-report methods may result in falsely positive responses.

Conclusion and Implications for Nursing Practice

More Americans are living longer, and the proportion of the U.S. population that is aged 65 years or older is growing rapidly. Life expectancy increased dramatically during the past century, from 47 years for Americans born in 1900 to 77 years for those born in 2001. In the United States, 20%

Table 3. Experience Results

Variable	DAP-Fear	DAP-Avoidance	DAP-Neutral	DAP-Approach	DAP-Escape	FATCOD
Years as RN^a						
Chi-square	6.161	10.447	4.050	5.783	15.821	18.374
df	3	3	3	3	3	3
Significance	0.104	0.015	0.256	0.123	0.001	< 0.0001
Years at cancer center^a						
Chi-square	5.312	5.841	9.789	3.594	15.370	10.950
df	3	3	3	3	3	3
Significance	0.150	0.120	0.020	0.309	0.002	0.012
Previous experience^b						
Mann-Whitney U	13,044.5	11,451.0	14,452.0	14,231.0	14,230.5	11,600.0
Z	-1.958	-3.767	-0.565	-0.798	-0.799	-3.536
Significance	0.050	< 0.0001	0.572	0.425	0.424	< 0.0001

^a Kruskal-Wallis^b Mann-Whitney U

DAP—Death Attitude Profile; FATCOD—Frommelt Attitude Toward Care of the Dying

of all Americans, about 70 million people, will have passed their 65th birthday by 2030 (Centers for Disease Control and Prevention, 2004).

With cancer being a disease that predominantly affects adults and an aging population, the absolute numbers of patients being diagnosed with cancer will continue to increase. Although many treatments are successful and patients go on to live their expected lifespans, many other therapies fail and these patients will not survive. Oncology nurses will continue to care for patients across the illness trajectory and will increasingly have to deal with death and the care of dying patients.

The goals of implementing an educational program regarding care of dying patients aim to foster more positive attitudes in younger and less experienced nurses by providing them with a strong background in palliative care and coping skills, instilling in them higher levels of palliative care competency, and exposing them to various EOL scenarios they will encounter in the oncology population.

The findings of the present study suggest that more experienced nurses view death from a neutral or more positive perspective than less experienced nurses. They also displayed a more positive attitude in caring for dying patients. Based on these results, an appropriate palliative care educational component should be incorporated into the new RN employee orientation course as well as the hospital's in-house training programs. Standardized curriculums, such as the End-of-Life Nursing Education Consortium (ELNEC) Core Curriculum (American Association of Colleges of Nursing, 2004), have been developed by experts and are used widely for this purpose. Results from this study and others reinforce the need for providing ongoing education on EOL care to oncology nurses.

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